POC #2 West Meade Place 45th day 1-25-20 / 70th 2-19-20

ATTACHMENT A

F 600

Free from Abuse and Neglect

1. On 11/2/19, resident #56 who slapped resident #29 on the arm was moved to another wing. On 11/4/19, resident #56 who slapped resident #3 on the arm was sent to ER for assessment by psych and possible med adjustment.

   On 11/27/19, after the incident where resident #26 slapped resident #18, the activities director arranged an appointment to shadow at another facility for continued education on activities for residents with different levels of dementia. On 12/11/19, Social Services Director arranged for an outside vendor to provide education for families and residents with higher BIMS scores who are alert and oriented, on how to live with people who have dementia.

   After the incident on 12/3/19, where Resident #65 hit Resident #18, a care plan conference was conducted by MDS Coordinator and Social Service Director on 12/5/19, with Resident #65 and her family with education and advisement that any further altercations would result in alternative placement discussions. On 11/27/19, and on 12/3/19, respectively, Resident #26 and Resident #65 were encouraged to ask staff for assistance when an issue arises involving a resident with dementia and not to try and resolve the situation on their own.

   On 12/6/19, the Social Services Director and DON met with the alert and oriented residents during a resident council meeting to review resident rights and responsibilities.

   On 11/4/19, and ending 12/6/19, the DON and/or ADON in-serviced all facility employees concerning Abuse and neglect, ways to prevent altercations with Alzheimer's and Dementia residents, as well as, techniques in how to reduce escalating situations with residents, and Staff members who assist in the dining rooms were instructed as to which residents have tendencies to quickly anger and get upset, and not to place them together at the same dining room table. This in- service was mandatory and was conducted either in person, in a classroom setting, or 1:1 either in person or by telephone. Any staff who fail to comply with the points of the in-services will be further educated and/or progressive discipline will began as indicated. The instructors or the in-service and Department Heads of each Department will ensure all employees have attended the in-services.

2. All residents have the potential to be affected.

   Beginning 12/16/19, and ending 12/19/19, the DON conducted an audit of residents with BIMS scores of 8 or lower and a history of aggression to identify those residents that need care plans that address aggressive behaviors. There were 7 residents identified. Beginning 1/15/20, the Social Services Director or Social worker will identify residents with aggressive behavior while completing their assessments on new admission and will ensure care plans are completed.

3. Beginning 1/13/20, the DON and Department Heads will question their staff randomly if they have witnessed any abuse, neglect, or Resident to Resident Altercation. This will be done weekly for the next 2 months and interviews will be acknowledged on a report form and submitted to DON for reporting to QAPI Committee meetings.

   Effective 1/13/20, the Unit Managers and Department Heads will administer a post-test following the in-services conducted on Abuse, Neglect, and Misappropriation of property and Resident to Resident Altercation weekly on both shifts for next 2 months. Number of exams administered with employee names who took the Post-test will be reported to the QAPI committee. **See Attachment A-1**.

4. Beginning 1/7/20, the DON, will monitor the reports of any abuse and exams administered, monthly and ensure education and training continues on hire, annually, and as needed.

   At the QAPI meetings the results of the monitoring of any Abuse or Neglect will be reviewed, however any concerns identified will be addressed as discovered, including any needed education and/or progressive discipline.

   Beginning 1/20/20, the DON will report monitoring outcomes of abuse or neglect at the QAPI Committee meetings.

Completion Date: 1/20/20

ATTACHMENT A-1

POST TEST FOR ABUSE, NEGLECT, AND MISAPPROPRIATION OF FUNDS

Name: _____ **Date:** _____

1) **Who is the Abuse Coordinator?**

_____

2) When do you report resident abuse or suspecting resident abuse?

a. Immediately on the next business day

b. Day shift at 8am

c. Immediately day or night to Supervisor

d. Report to supervisor immediately then the Supervisor will notify abuse coordinator immediately day or night

3) All new employees must be trained during:

a. Orientation

b. Departmental orientation

c. On-going training sessions

d. All of the above

4).True or False

The definition of Abuse is defined as the willful inflection of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.

5) True or False

Failure to report abuse, neglect, or misappropriation of funds may result in legal/criminal action being filed against the individual(s) withholding such information.

6) True or False

Is Resident to Resident Altercations a reportable event?

ATTACHMENT D

F 658

Services Provided Meet Professional Standards

1. Upon being made aware of the deficient practice on 12/11/19, of not obtaining a HgbA1c on Resident # 82 when ordered in 10/19, the ADON notified the PCP of the missed lab and received another order for the lab test to be done 12/11/19. This was completed and reported to MD. On 12/11/19, the DON added the restraint reduction assessment to Resident #82's orders for Nursing. The first Restraint Reduction Assessment was completed on 12/11/19.

   On 1/7/20, the DON changed the process for monitoring labs and orders written each day. The new process is a 24-hour chart check. **See Attachment D-1.**

   Beginning 12/23/19, and ending 1/20/20, the DON, ADON, and /or Nursing Supervisors in-serviced all licensed nursing staff (RNs and LPNs) concerning following physician orders, how to follow/enter orders, 24-hour chart check, and adding a restraint reduction assessment to the MAR for each resident to ensure nurse does quarterly reviews. Also discussed was the approval of the DON or ADON's approval before use of restraints. This in- service was mandatory and was conducted either in person, in a classroom setting, or 1:1 either in person or by telephone. Any staff who fail to comply with the points of the in-services will be further educated and/or progressive discipline will begin as indicated. The instructors of the in-service will ensure all employees have attended the in-services.

2. All residents have the potential to be affected. On 12/11/19, and ending 12/31/19, the ADON initiated chart reviews on all residents for the past months to identify any orders that may have not been completed. None were found.

3. On 12/30/19, the DON created a chart checklist for Nursing Supervisors to use to review charts. **See Attachment D-2.**

   Beginning on 12/30/19, nursing supervisors will perform random chart reviews weekly for 2 months for any orders found to have been entered into the system incorrectly, or to not have been followed. They will report any issues to the physician and the DON for corrective action at that time. Results of chart checks will be discussed at the QAPI meeting.

4. Beginning 1/7/20, the nursing supervisors will provide weekly reports to the DON of the charts reviewed and if any missed orders found, however, any concerns identified will be addressed as discovered, including any needed education and/or progressive discipline.

   Beginning 1/20/20, the DON will report monitoring outcomes of MD orders at the QAPI Committee meetings.

Completion Date: 01/20/20

SUBJECT: 24 hour Chart Check	REFERENCE: #
	PAGE: 1 OF: 2
AGENCY: ADMINISTRATION	EFFECTIVE: 02/15/11
SCOPE: CLINICAL	REVISED: 02/15/17

Purpose:

The purpose of the 24 hour chart check is to ensure completeness of medical record, accuracy in the transcription of new orders, completion of admission process including orders, assessments, care plan and nurse aid documentation.

Policy:

All new Admissions will be reviewed by the 7p – 7a licensed nurse to ensure that all orders and/or change orders are accurately reflected and noted on the MAR, TAR, care guide for CNAs, and Care Plan. Any order written during the past 24 hours should be reviewed for accuracy and completeness.

Procedure:

A. Any new orders will trigger the following action:

1. Medication
   - Review MAR to ensure that new or changed meds have been entered on medical record correctly.
   - Verification that d/c'd or changed medications have been d/c'd from MAR & removed from med cart
   - Medication ordered has a corresponding reason – review diagnosis list and H&P for indication. If no indication available communicate via 24hr report sheet that indication is needed for follow up by day shift
   - Verify that antibiotics have a specified length of time to be administered and infection is noted on the 24 hour Report with the symptons displayed by resident. If stop date for antibiotic is not indicated communicate via 24hr report sheet that stop date is needed for follow up by day shift
   - Verify that the need to check pulse and/or blood pressure is noted on MAR for cardiac and/or antihypertensive meds and that parameters for holding medication are included in the order if applicable.
   - Verify the PPDs are initiated, and scheduled for reading and second step ordered and scheduled for reading. When PPDs are administered, check for the following information recorded in the immunization section: temperature, Lot #, Expiration date, and site of injection.
   - Verify that weekly skin assessments, monthly summary, quarterly assessments have been entered in MATRIX according to the schedule

2. Treatments
    - Review TAR to ensure that all new or changed wound treatment orders have been added and dated
    - Verify that previous treatments have been discontinued
    - Verify that all new admission treatment orders are co-signed and dated

3. Restraints
    - Order present and complete – including all required components including indication, type and duration
    - Verify Pre-restraining Assessment has been completed and if not communicate via 24hr report sheet that indication is needed for follow up by day shift
    - Verify Restraint consent by family is on chart
4. Labs
    - Verify documentation of a date due on the MAR for all lab orders – Verify that lab requisition forms have been completed for labs ordered the following morning per MAR
    - Ensure all labs are available for MD/NP review when results are obtained

5. Other orders – verify transcription to MAR/TAR as indicated
6. Diet
    - Verify presence of diet order on admission
    - Verify MAR and TAR are updated to reflect any changes

ATTACHMENT D-2

Mark N if indicator not present
Leave blank if indicator is correct or present

MEDICAL RECORD REVIEW WORKSHEET

MONTH: _____

RESIDENT INITIALS								Comments
SECTION I: NURSING ADMISSION REVIEW								
Admission Assessment completed								
Admission Assessment completed timely								
Allergies and/or abnormal drug reactions documented on MAR, front of chart, and Admission Assessment.								
Care plan established within 48 hrs								
Skilled Nursing care identified								
Care Plan established for Resident that addresses identified problems								
Flu and Pneumoccocal Consent form complete and signed. If marked yes, was vaccine given?								
Vital signs documented including Ht & Wt. on admission								
If O2 used, method of administration documented, protocol for care - orders on MAR								
If inhalants are ordered, Respiratory Assessment protocol orders established								
If Foley catheter present, protocol for care entered on MAR								
MAR complete with signatures								
If Pain Medication given was Pain assessed, rated and follow-up documented?								

Mark N if indicator not present
Leave blank if indicator is correct or present

MEDICAL RECORD REVIEW WORKSHEET

MONTH: _____

RESIDENT INITIALS								Comments
If Antibiotics ordered, was charting done each shift concerning side effects, etc?								
H&P on chart, signed, and current								
Lab work and X-ray orderd timely and results on chart?								
Quarterly Assessments on MAR and completed timely & accurate								
If Wound Care provided is there a care plan and documented care present?								
If IV therapy ordered, is care documented each shift?								
If sliding scale ordered, blood sugars are recorded with accurate documentation, MD called if needed, snack given.								
Discharge note written /order present, discharge instruction done, medication reconciliation done with signature?								
TOTAL INDICATORS COMPLETED CORRECTLY:								
TOTAL INDICATORS COMPLETED INCORRECTLY:								

Reviewing Staff:_____ Date:____/____/____

ATTACHMENT E

F 695

Respiratory/Tracheostomy Care and Suctioning

1. Upon being made aware of the deficient practice on 12/11/19, not properly storing suction tubing on Resident # 41, the Respiratory Director immediately discarded the suctioning tubing.

   On 12/21/19, the DON and the Respiratory Director updated the inline/sterile suctioning policy and procedure by adding the statement "discard tubing if not connected to cap". **See Attachment E-1**.

   Beginning 12/23/19, and ending 1/20/20, the DON, ADON, and the Respiratory Director in-serviced all licensed nursing staff (RNs and LPNs) and Respiratory Therapist concerning the updated inline/sterile suctioning policy and procedure i.e. discarding tubing that is found not to be connected to the equipment. This in-service was mandatory and was conducted either in person in a classroom setting, or 1:1 either in person or by telephone. Any staff who fail to comply with the points of the in-services will be further educated and/or progressively discipline will begin as indicated. The instructors of the in-service will ensure all employees have attended the in-services.

2. All residents have the potential to be affected. On 12/11/19, the Respiratory Director checked all resident's room in the respiratory unit with tracheostomy who had a suction canister with tubing at bedside was stored appropriately. All other Resident's suctioning tubing was stored appropriately.

3. Beginning on 12/30/19, Respiratory Director will conduct weekly rounds randomly on each shift for 2 months for suction tubing storage. The Director will report any issues found with storage of suction tubing to the DON for corrective action at that time. Results of room checks will be discussed at the QAPI meeting.

4. Beginning 1/7/20, the Respiratory Director will provide weekly reports to the DON of the room checks and if any suction tubing found stored incorrectly, however, any concerns identified will be addressed as discovered, including any needed education and/or progressive discipline. Beginning 1/20/20, the DON will report monitoring outcomes of suction tube storage at the QAPI Committee meetings.

Completion Date: 01/20/20

ATTACHMENT E-1

Inline Tracheostomy Suction

1. To remove secretions
2. Prevent accumulation of secretions
3. To provide access to patients requiring frequent suction.
4. To decrease risk of infection through a closed suction system.

Assessment Focus:

Respiratory signs and symptoms of hypoxemia

Rapid, shallow respirations or slow respirations

Pulse rate and rhythm

Use of accessory muscles to breathe

Audible sounds (wheezing, stridor) Nasal Flaring

Skin

Cyanosis of nail beds and lips resulting from vasoconstriction and

Diminished blood flow

PROCEDURE:

Equipment:

1. Closed Suction Catheter
2. Suction Machine fully assembled.
3. Normal Saline if applicable
4. Sterile Water

Procedure:

1. Identify patient and introduce self
2. Explain procedure to patient and family and assess patient knowledge as it pertains to safety
3. Wash hands and observe standard/universal precautions
4. Open sterile water and saline vials
5. Open port of Inline catheter
6. Attach catheter to suction tubing and turn on suction machine.
7. Pre-oxygenate patient with oxygen if applicable.
8. Lavage trach with Saline via saline port on catheter if necessary.

9. Insert catheter into trach and pull back slightly when resistance is met and depress finger port on catheter to begin suction intermittently while withdrawing catheter for no longer than 15 seconds total procedure.
10. Repeat as necessary, allowing patient to rest between passes.
11. When complete, rinse suction catheter through canister.
12. Attach connective tubing to closing cap on lid of canister.
13. Assess patient.
14. Dispose of items in appropriate waste container
15. Wash hands
16. Document data in patient chart.

Potential Problems:

1. Hypoxemia.
2. Gag reflex activation causing vomiting.
3. Bradycardia from vagal stimulation.

Patient Response to Treatment:

1. Respiratory status and improvement
2. Vital signs for stabilization or changes.
3. Improvement in skin color.

DOCUMENTATION:

Document in progress notes the following:

1. Breath Sounds
2. Pulse
3. Respiratory Rate
4. Pulse Oximetry
5. Date and Time
6. Amount, Color, Consistency

INFECTION CONTROL:

Infection can occur if equipment is not changed and cleaned properly.

1. Dispose of entire suction kit after each use.
2. Change suction assembly disposables monthly and document in EMAR
3. . ALWAYS DISCARD SUCTION CATHETER AFTER EACH USE
4. If tubing is not attached to cap-discard.

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Tracheostomy Suction

1. To remove secretions
2. Prevent accumulation of secretions

Assessment Focus:

Respiratory signs and symptoms of hypoxemia

Rapid, shallow respirations or slow respirations

Pulse rate and rhythm

Use of accessory muscles to breathe

Audible sounds (wheezing, stridor) Nasal Flaring

Skin

Cyanosis of nail beds and lips resulting from vasoconstriction and

Diminished blood flow

PROCEDURE:

Equipment:

1. Suction Kit
2. Suction Machine fully assembled.
3. Normal Saline if applicable
4. Sterile Water

Procedure:

1. Identify patient and introduce self
2. Explain procedure to patient and family and assess patient knowledge as it pertains to safety
3. Wash hands and observe standard/universal precautions
4. Open suction kit, sterile water and saline vials
5. Apply gloves maintaining sterility in dominant hand.
6. With sterile dominant hand wrap suction catheter around palm
7. Attach catheter to suction tubing using non-sterile hand and turn on suction machine.
8. Pre-oxygenate patient with oxygen if applicable.
9. Lavage trach with Saline if necessary.

10. Insert catheter into trach and pull back slightly when resistance is met and depress finger port on catheter to begin suction intermittently while withdrawing catheter for no longer than 15 seconds total procedure.
11. Repeat as necessary, allowing patient to rest between passes.
12. When complete, rinse suction catheter through canister.
13. Remove catheter and discard in prepared trash receptacle
14. Attach connective tubing to closing cap on lid of canister.
15. Dispose of items in appropriate waste container
16. Wash hands.
17. Assess patient.
18. Document data in patient chart.

Potential Problems:

1. Hypoxemia.
2. Gag reflex activation causing vomiting.
3. Bradycardia from vagal stimulation.

Patient Response to Treatment:

1. Respiratory status and improvement
2. Vital signs for stabilization or changes.
3. Improvement in skin color.

DOCUMENTATION:

Document in progress notes the following:

1. Breath Sounds
2. Pulse
3. Respiratory Rate
4. Pulse Oximetry
5. Date and Time
6. Amount, Color, Consistency

INFECTION CONTROL:

Infection can occur if equipment is not changed and cleaned properly.

1. Dispose of entire suction kit after each use.
2. Change suction assembly disposables every week and document in EMAR.
3. ALWAYS DISCARD SUCTION CATHETER AFTER EACH USE.

4. If tubing is not attached to cap- discard

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445203	A. BUILDING _____ B. WING _____	12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST MEADE PLACE	1000 ST LUKE DRIVE NASHVILLE, TN 37205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey and complaint investigation #TN00049689, TN00049705, TN00049984, TN00049985 and TN00049992 were completed on 12/11/19 at West Meade Place. Deficiencies were cited for the recertification survey and complaint investigation #TN00049689 TN00049984, TN00049985 and TN00049992 under 42 CFR PART 483, Requirements for Long Term Care Facilities.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, facility documentation review and interview the facility failed to ensure 3 (#3, #18, #56) of #35 residents reviewed was free from abuse. The findings include:	F 600	See Attachment A	

RECEIVED
DEC 16 2019
BY:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ADMINISTRATOR | (X6) DATE: 12-30-19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 600	Continued From page 1 Facility policy review Abuse, Neglect, Misappropriation of Funds, revised 9/28/19 revealed, "...to establish a policy and procedure designed to prohibit abuse, neglect, exploitation, involuntary seclusion of residents and/or misappropriation of resident property...the facility has a zero tolerance policy for abuse, involuntary seclusion, neglect, exploitation and misappropriation of resident property...any individual observing an incident of resident abuse or suspecting resident abuse must immediately report such incident to the Administrator or Director of Nursing...allegation of Abuse and/or Serious Bodily Injury-2 Hour Limit: if the events that cause the reasonable suspicion of abuse immediately, but not later than 2 hours after forming the suspicion..." Review of the facility investigation dated 11/4/19 revealed a witnessed altercation between Resident #3 and Resident #56. Continued review revealed Resident #56 slapped Resident #3 on 11/3/19. Medical record review revealed Resident #3 was admitted to the facility on 6/5/18 with diagnoses which included Hemiplegia and hemiparesis. Dementia without Behavioral Disturbance, Anxiety Disorder and Major Depressive Disorder. Medical record review of Resident #3's Quarterly Minimum Data Set (MDS) dated 9/4/19 revealed the resident had a Brief Interview of Mental Status (BIMS) score of 99, indicating the resident was unable to complete the interview. Medical record review revealed Resident #56 was admitted to the facility on 5/22/18 with diagnoses which included Alzheimer's Disease and Vascular	F 600		

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F 600	Continued From page 2 Dementia with Behavioral Disturbance. Medical record review of Resident #56's Quarterly MDS dated 8/26/19 revealed the resident had a BIMS score of 99 indicating the resident was unable to complete the interview. Continued review revealed the resident exhibited verbal behaviors. Interview with Certified Nursing Technician (CNT) #3 on 12/11/19 at 12:50 PM in the Atrium Dining room revealed Residents #3 and #56 had a physical altercation. Continued interview revealed Resident #56 smacked Resident #3. Interview with the Director Of Nursing (DON) on 12/11/19 at 3:18 PM in her office revealed she was informed on 11/3/19 of a verbal atercation between Resident #3 and #56. Continued interview revealed she was notified the next day 11/4/19 the altercation between Resident #3 and Resident #56 became physical. Continued interview when asked to look at the incident date and the reporting date confirmed "It was turned in late because I wasn't aware of the possible hitting until the next day after the incident." Review of facility investigation initiated on 11/2/19 revealed an unwitnessed altercation occurred between Resident #29 and Resident #56. Medical record review revealed Resident #29 was admitted to the facility on 10/24/18 with diagnoses which included Parkinson's Disease. Medical record review of Resident #29's Quarterly MDS dated 10/13/19 revealed the resident had a BIMS score of 13 indicating the resident had no cognitive impairment. Continued review revealed	F 600		

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F 600	Continued From page 3 the resident exhibited no behaviors. Interview with CNT #1 on 12/9/19 at 2:28 PM in the 3rd floor nurse station revealed Resident #56 was in Resident #29's room; Resident #29 was telling Resident #56 she needed to leave because that wasn't her room. Continued interview she stated "I didn't see anything but Resident #29 told me Resident #56 hurt her finger and smacked her arm; I removed Resident #56 and notified the nurse." Interview with Resident #29 on 12/09/19 at 11:34 AM in her room when asked concerning an altercation with her and Resident #56 she stated, "I was in my room watching T.V. [television] when the lady came into my room; I asked her to leave the room and she kept coming, she tried going around the corner of my bed so I tried to put my table in front of her to keep her from coming into my room. I kept pushing the table in front of her and she kept kicking my table then she hit me on my right arm." Interview with the DON on 12/11/19 at 3:17 PM in her office revealed she was notified that Resident #56 hit Resident #29 on the arm. Continued interview confirmed Resident #56 hit Resident #29. Review of the facility's investigation dated 11/27/19 revealed an unwitnessed physical altercation between Resident #18 and Resident #26. Further review revealed Resident #26 told the Director of Nursing that she became frustrated because she was trying to watch television when Resident #18 and Resident #3 were arguing; she (named Resident #26) asked them (Resident #3 and #18) to be quiet and they	F 600		

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F 600	Continued From page 4 wouldn't be quiet so she slapped Resident #18 on the face. Medical record review revealed Resident #26 was admitted to the facility on 4/6/18 with diagnoses which included Convulsions and Mood Disorder. Review of Resident #26's Quarterly MDS dated 10/10/19 revealed the resident had a BIMS score of 14, indicating the resident had no cognitive impairment. Interview with Resident #26 on 12/9/19 at 3:02 PM in the third floor dining room when asked about the incident between her and Resident #18 she stated, "We were kind of fussing last Thursday in the dining room; she didn't want me to sit where I was sitting and cussed me so I slapped her (named resident #18) across the face." Interview with the DON on 12/10/19 at 6:40 PM in her office revealed a physical altercation between Resident #18 and Resident #26 was reported to her on 11/27/19. Continued interview revealed Resident #26 slapped Resident #18 across the face. Review of the facility investigation dated 12/3/19 revealed a physical altercation between Resident #65 and Resident #18 occurred in the dining room witnessed by Resident #58. Medical record review revealed Resident #18 was admitted to the facility on 4/19/96 with diagnoses which included Hemiplegia and Hemiparesis. Medical record review of Resident #18's Quarterly MDS dated 10/2/19 revealed the resident had a	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445203	A. BUILDING _____ B. WING _____	12/11/2019

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F 600	Continued From page 5 BIMS score of 4, indicating the resident had severe cognitive impairment. Medical record review revealed Resident #58 was admitted to the facility on 10/6/17 with diagnoses which included Type 2 Diabetes. Medical record review of Resident #58's MDS dated 10/20/19 revealed the resident had a BIMS score of 15, indicating the resident had no cognitive impairment. Resident #65 was admitted to the facility on 8/19/16 with diagnoses which included Hemiplegia and Hemiparesis. Review of Resident #65's Quarterly MDS dated 11/20/19 revealed the resident had a BIMS score of 15, indicating the resident had no cognitive impairment. Interview with the Resident #65 on 12/9/19 at 2:53 PM in the third floor dining room when asked about an incident between her and Resident #18, she stated "(named Resident #18) has a tendency to cuss me and I got mad and just went off and hit her." Interview with CNT #2 on 12/10/19 at 3:35 PM in the third floor nurses station when asked about the altercation between Resident #18 and #65 she stated, "I heard (named Resident #18) screaming and I went in the dining room and she was sitting at the table with a cup of coffee and (named Resident #65) had a hold of (named Resident #18) arm." Continued interview revealed she removed Resident #18 and notified her supervisor.	F 600		

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	445203	A. BUILDING _____ B. WING _____	12/11/2019

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F 600	Continued From page 6 Interview with Resident #58 on 12/10/19 at 4:02 PM in the resident's room when asked if she witnessed an altercation between two residents she stated "(named Resident #65) can't get along with (named Resident #18); They started arguing and (named Resident #65) went to (named Resident #18) table and started fighting with her (named Resident #18), hitting her." Interview with the DON on 12/10/19 at 6:52 PM in her office revealed the nursing supervisor notified her of a physical altercation between Resident #18 and Resident #65. Continued interview confirmed Resident #65 grabbed Resident #18's arm and Resident #18 hit Resident #65.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609	See Attachment B	

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F 609	Continued From page 7 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on facility policy review and interview the facility failed to report an allegation of abuse timely for Resident #3. The findings include: Facility policy review Abuse, Neglect, Misappropriation of Funds, revised 9/28/19 revealed, "...to establish a policy and procedure designed to prohibit abuse, neglect, exploitation, involuntary seclusion of residents and/or misappropriation of resident property...the facility has a zero tolerance policy for abuse, involuntary seclusion, neglect, exploitation and misappropriation of resident property...any individual observing an incident of resident abuse or suspecting resident abuse must immediately report such incident to the Administrator or Director of Nursing...allegation of Abuse and/or Serious Bodily Injury-2 Hour Limit: if the events that cause the reasonable suspicion of abuse immediately, but not later than 2 hours after forming the suspicion..." Review of the facility investigation dated 11/4/19 revealed a witnessed altercation between Resident #3 and Resident #56. Continued review revealed on 11/3/19 Resident #56 slapped Resident #3. Further review revealed the Director	F 609		

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F 609	Continued From page 8 of Nursing (DON) was notified of the incident on 11/4/19. Continued review revealed the DON reported the incident to the state agency on 11/4/19. Medical record review revealed Resident #3 was admitted to the facility on 6/5/18 with diagnoses which included Hemiplegia and Hemiparesis, Dementia without Behavioral Disturbance, Anxiety Disorder and Major Depressive Disorder. Medical record review of Resident #3's Quarterly Minimum Data Set (MDS) dated 9/4/19 revealed the resident had a Brief Interview of Mental Status (BIMS) score of 99, indicating the resident was unable to complete the interview. Medical record review revealed Resident #56 was admitted to the facility on 5/22/18 with diagnoses which included Alzheimer's Disease and Vascular Dementia with Behavioral Disturbance. Medical record review of Resident #56's MDS dated 8/26/19 revealed the resident had a BIMS score of 99, indicating the resident was unable to complete the Interview. Continued review revealed the resident exhibited verbal behaviors. Interview with Licensed Practical Nurse (LPN) #2 on 12/11/19 at 10:40 AM on the third floor hallway revealed he didn't witness the altercation between Resident #3 and #56. Continued interview revealed he was unaware of the incident until he was going to clock out and an unnamed tech informed him of a physical altercation between Resident #3 and Resident #56. Continued interview revealed he reported the incident to his supervisor.	F 609		

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F 609	Continued From page 9 Interview with Certified Nursing Technician (CNT) #3 on 12/11/19 at 12:50 PM in the Atrium Dining room revealed Resident #3 and Resident #56 had a physical altercation. Further interview revealed Resident #56 smacked Resident #3. Continued interview revealed CNT #3 reported the incident to her supervisor. Interview with the Director Of Nursing on 12/11/19 at 3:18 PM in her office revealed the staff informed her on 11/4/19 of an altercation between Resident #3 and Resident #56 that occurred on 11/3/19. Continued interview when asked to look at the incident date and the reporting date confirmed "It was turned in late because I wasn't aware of the possible hitting until the next day after the incident."	F 609		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined	F 657	See Attachment C	

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F 657	Continued From page 10 not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, observation and interview, the facility failed to revise a care plan for 1 (#20) of 35 residents reviewed for care plans. The findings include: Review of the facility policy, Care Plans, Comprehensive Person-Centered, revised December 2016, revealed "...Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's conditions change...At least quarterly, in conjunction with the required quarterly Minimum Data Set (MDS)..." Medical record review revealed Resident #20 was admitted to the facility on 9/26/19 with diagnoses which included Respiratory Failure. Medical record review of Resident #20's Physician Orders dated 9/29/19 revealed "Isolation: Patient on contact and droplet for Extended Spectrum Beta-Lactamases (ESBL)-Escherichia Coli (E-Coli) in urine and Pseudomonas in Sputum. Medical record review of Resident #20's	F 657		

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F 657	Continued From page 11 comprehensive care plan dated 9/10/19 revealed Resident #20 required isolation related to DX (diagnosis) ESBL in her urine. Continued review revealed no care plan for Isolation related to Pseudomonas in Sputum. Interview with the MDS Coordinator on 12/11/19 at 8:30 PM in the conference room confirmed physician orders were reviewed with MDS updates and care plans were updated according to the orders. Further interview confirmed Resident #20's care plan was not updated for respiratory precautions. She stated "I missed it."	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review and interview the facility failed to follow physician's orders for 2 (#'s 4, #82) residents of 35 residents reviewed for physician orders being followed. The findings include: Facility policy review, Physician Orders, revised June 2004, revealed "...Physician orders must be given and managed in accordance with applicable laws and regulations...all staff providing care to residents must follow the physician orders..."	F 658	See Attachment D	

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F 658	Continued From page 12 Medical record review revealed Resident #4 was admitted to the facility on 6/7/19 with diagnoses which included Guillain-Barre syndrome-Miller Fisher Syndrome Variant, Dependence on Respirator Status and Diabetes. Medical record review of Resident #4's Physician Order Report dated 7/8/19 revealed "...HgbA1C [glycated hemoglobin, a blood test to determine blood sugar levels over a 3 month period] every 3 months..." Medical record review of Resident #4's laboratory results revealed there was no HgbA1C obtained for the month of October 2019. Interview with the Assistant Director of Nursing on 12/11/19 at 2:50 PM in the conference room confirmed Resident #4 did not have a HgbA1C obtained in October 2019. She stated "the nurse who put the order in the computer placed the order in the general orders instead of the lab order; so it didn't get done." Interview with the Director of Nursing (DON) on 12/11/19 at 3:18 PM in her office confirmed the HgbA1C was not obtained in October 2019 for Resident #4. Medial record review revealed Resident #82 was admitted to the facility on 3/11/19 with diagnoses which included Hemiplegia and Hemiparesis, Altered Mental Status, Bipolar Disorder, Generalized Anxiety Disorder and Mood Disorder. Medical record review of Resident #82's Quarterly Minimum Data Set (MDS) dated 11/28/19 revealed Resident #82 has a Brief Interview for Mental Status score of 3, indicating severe	F 658		

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F 658	Continued From page 13 cognitive impairment, Continued review revealed limb restraint used daily. Medical record review of Resident #82's Physician's Orders dated 6/9/19 revealed "...Quarterly Restraint Reduction Assessment once a day every 90 days..." Medical record review revealed Resident #82 had no quarterly restraint reduction assessments. Interview with the Director of Nursing (DON) on 12/11/19 at 2:20 PM in her office confirmed no quarterly restraint reduction assessments for Resident #82 had been completed.	F 658		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on facility procedure review, medical record review, observation and interview, the facility failed to properly store suction tubing prevent the spread of infection for 1 resident (#41) of 48 residents who received respiratory services. The findings include:	F 695	See Attachment E	

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F 695	Continued From page 14 Facility procedure review, Tracheostomy Suction, undated, and Inline Tracheostomy Suction, undated, revealed "...Attach connective tubing to closing cap on lid of canister..." Medical record review revealed Resident #41 was admitted to the facility on 2/8/19 with diagnoses which included Acute Respiratory Failure With Hypoxia, Encounter for Attention To Tracheostomy, Infection of Tracheostomy stoma, and Dysphagia. Medical record review of Resident #41's Physician Orders dated 2/8/19 revealed "...Tracheal Suction..." Observation on 12/9/19 at 12:43 PM in Resident #41's room revealed suction tubing laying on bedside table, not connected to machine and exposed.. Interview with Respiratory Therapist #2 on 12/9/19 at 12:43 PM in Resident #41's room confirmed suction tubing was left exposed and not connected to the suction canister. Interview with the Respiratory Director on 12/11/19 at 8:52 AM in the conference room confirmed "if there is an open tube it should be covered while not in use and if found uncovered the tubing would be changed."	F 695		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include,	F 758	See Attachment F	

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F 758	Continued From page 15 but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic	F 758		

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F 758	Continued From page 16 drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review and interview the facility failed to write a stop date for an as needed Psychotropic medication for 2 (#33, #56) of 14 residents reviewed for psychotropic medications. The findings include: Facility policy review, Antipsychotic Medication Use, dated 3/15/18 revealed "...The need to continue PRN [as needed] orders for psychotropic medications beyond 14 days requires that the practitioner document the rationale for the extended order. The duration of the PRN order will be indicated in the order..." Medical record review revealed Resident #33 was admitted to the facility on 10/9/19 with diagnoses which included Anxiety Disorder. Medical record review of Resident #33's Physician Orders dated 11/7/19 revealed "...alprazolam [an antianxiety medication] tablet 0.25 mg[milligram]1 tab [tablet] gastric tube Three Times A Day - PRN..." Medical record review of Resident #33's Pharmacy Communication/Recommendations dated 11/27/19 revealed "...Alprazolam 0.25mg...PRN psychotropic medications are limited to 14 days, unless a prescriber documents in the medical record rationale, including duration, for extended therapy..."	F 758		

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F 758	Continued From page 17 Interview with the Director of Nursing (DON) on 12/11/19 at 6:55 PM in her office revealed when asked to review Resident #33's Physician Order dated 11/7/19 for PRN Alprazolam confirmed there was no stop date for the as needed anti-anxiety medication. Medical record review revealed Resident #56 was admitted to the facility on 11/08/19 with diagnoses which included Alzheimers Disease, Vascular Dementia with Behavioral Disturbances and Generalized Anxiety Disorder. Medical record review of Resident #56's Physician Orders dated 11/15/19 revealed "...Ativan (lorazapam) [medication used to treat anxiety] Schedule IV tablet; 0.5 mg; oral Special Instructions: anxiety and tremors every 3 hours-PRN..." Medical record review of Resident #56's Pharmacy Communication/Recommendations dated 11/25/19 revealed "...Ativan 0.5 mg...PRN psychotropic medications are limited to 14 days, unless a prescriber documents in the medical record rationale, including duration, for extended therapy..." Medical record review of Resident #56's Medication Administration Record dated December 2019 revealed the resident received Ativan on 12/3/19 at 10:19 PM and December 4, 2019 at 10:41 PM. Interview with the Director of Nursing on 12/11/19 at 8:55 AM in her office confirmed there was no stop date for Resident #56's PRN Ativan.	F 758		

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F 758	Continued From page 18 Interview with Resident #33 and #56's Physician on 12/11/19 at 6:45 PM at the second floor nurse station he stated "generally don't write stop dates and the resident needs these medications."	F 758		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880	See Attachment G	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 19 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on facility policy review, record review, observation and interview, the facility failed to post correct signage for droplet isolation precautions for 1 resident (#20) and failed to wear proper personal protective equipment (PPE)	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445203	A. BUILDING _____ B. WING _____	12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST MEADE PLACE	1000 ST LUKE DRIVE NASHVILLE, TN 37205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 20 before entering the room for 1 (#38) of 14 residents reviewed for transmission based precautions. The findings include: Facility policy review, Isolation, dated May 1, 2008 and revised October 2016 revealed "...Signs-Use color coded signs and/or other measures to alert staff of the implementation of Isolation or Droplet Precautions...Transmission-Based Precautions will be used whenever measures more stringent than Standard Precautions are needed to prevent or control the spread of infection...In addition to Standard Precautions, Implement Droplet Precautions for an individual documented or suspected to be infected with microorganisms transmitted by droplets..." Medical record review revealed Resident #20 was admitted to the facility on 9/26/19 with diagnoses which included Renal Insufficiency, Renal Failure, or End Stage Renal Disease (ESRD), Diabetes Mellitus (DM), Respiratory Failure and Dependence on Renal Dialysis. Medical record review of Resident #20's Admission Minimum Data Set (MDS) Assessment dated 10/3/19 revealed the resident required suctioning and tracheostomy care. Medical record review of Resident #20's Physician Orders dated 9/29/19 revealed "...Isolation: Patient on contact and droplet for Extended Spectrum Beta-Lactamases (ESBL)-Escherichia Coli (E-Coli) in urine Pseudomonas in Sputum..." Observation on 12/9/19 at 11:20 AM outside of	F 880		

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	445203	A. BUILDING _____ B. WING _____	12/11/2019

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F 880	Continued From page 21 Resident #20's room revealed signage on the door was for contact isolation and no signage for respiratory isolation. Observation on 12/10/19 at 9:49 AM outside of Resident #20's room revealed Respiratory Signage "..speak with nurse before entering room...wash hands, mask and gloves..." Interview with the Registered Respiratory Therapist (RRT) on 12/09/19 at 11:25 AM revealed resident #20 was in contact and droplet isolation. Further interview confirmed the Droplet Precautions were not posted. Interview with the ADON on 12/11/19 at 4:13 PM in her office confirmed she expected to find the correct isolation signage and PPE's on respective doors per facility policy. Medical record review revealed Resident #38 was admitted to the facility on 10/15/19 with diagnoses which included Encounter for attention to Tracheostomy, Dependence on Supplemental Oxygen and Dependence on Renal Dialysis. Medical record review of Resident #38's Admission MDS dated 10/22/19 revealed the resident received suctioning and tracheostomy care. Medical record review of Resident #38's Physician Orders dated 11/25/19 revealed "...Isolation: Patient on droplet isolation for Pseudomonas Sputum..." Observation on 12/11/19 at 8:15 AM outside of Resident #38's room revealed Registered Nurse (RN) #1 entered the resident's room without	F 880		

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F 880	Continued From page 22 applying proper PPE. Interview with RN #1 confirmed she did not apply the proper PPE before entering resident #38's room. Interview with the Director of Nursing (DON) on 12/11/19 at 8:15 AM in her office confirmed nursing must apply proper PPE prior to entering isolation rooms at all times.	F 880		

ATTACHMENT A

F 600
Free from Abuse and Neglect

1. On 11/2/19, resident #56 who slapped resident #29 on the arm was moved to another wing. On 11/4/19, resident #56 who slapped resident #3 on the arm was sent to ER for assessment by psych and possible med adjustment. On 11/4/19, staff in-services began involving abuse and neglect, ways to prevent altercations with Alzheimer's and Dementia residents, as well as, techniques in how to reduce escalating situations with residents. Staff members who assist in the dining rooms were instructed as to which residents have tendencies to quickly anger and get upset, and not to place them together at the same dining room table. All of these in-services have been completed. On 11/27/19, after the incident where resident #26 slapped resident #18, the activities director arranged an appointment to shadow at another facility for continued education on activities for residents with different levels of dementia. The activities director shadowed at Brookdale on 12/11/19. Social services reached out to *A Place for Mom* for education with families and residents with higher BIMS scores who are alert and oriented on living with people who have dementia. After the incident on 12/3/19, where Resident #65 hit Resident #18, a care plan was held on 12/5/19, with Resident #65 and her family with education and advisement that any further altercations would result in alternative placement discussions. On 11/27/19, and on 12/3/19, respectively, Resident #26 and Resident #65 were encouraged to ask staff for assistance when an issue arises involving a resident with dementia and not to try and resolve the situation on their own. On 12/6/19, the social services director and DON met with the alert and oriented residents during a resident council meeting to review resident rights and responsibilities.

2. Residents who have BIMS scores of 8 or lower and have a history of aggression were identified and new residents will be identified on admission. The above corrective actions were completed at the time of the events.

3. In-services involving ways to prevent altercations with Alzheimer's and Dementia residents, as well as techniques in how to reduce escalating situations with residents along with training for staff who assist in the dining room to identify which residents have tendencies to quickly anger and upset, and not to place them together at the same dining room table will be added to facility orientation and annual education.

4. Employee education files will be reviewed for the next 3 months to ensure the above training is completed. The review of the education files will be presented at the Quarterly QAPI meeting.

Completion Date: 12/31/19

ATTACHMENT B

F 609

Reporting of Alleged Violation

1. On 11/4/19, staff in-services began involving abuse and neglect, ways to prevent altercations with Alzheimer's and Dementia residents, as well as, techniques in how to reduce escalating situations with residents. Staff who assist in dining rooms were instructed as to which residents have tendencies to quickly anger and upset, and not to place them together at the same dining room table. All these in-services were been completed on 11/27/19. Employees who did not notify the Abuse Coordinator in a timely manner received disciplinary actions.

2. All residents have the potential to be effected by abuse. Continued abuse and abuse reporting education occurs throughout the year with new employee education, annual education, and during general staff meetings.

3. A new checklist has been developed and put into place for the supervisors regarding timeliness of abuse reporting and the components of an investigation. A new weekend supervisor has been put into place and trained on the importance of recognizing signs of abuse and the timely reporting of such.

4. Any abuse allegations will be evaluated for timeliness and results will be reported during quarterly QAPI meetings.

Completion Date: 12/31/19

ATTACHMENT C

F 657
Care Plan Timing and Revision

1. On 12/11/19, the Care Plan for Resident #20 was updated for the current isolation precautions.

2. Starting 12/11/19, the infection control nurse will be reviewing physician orders and culture results daily. The ICN will notify staff including the MDS nurses (who write care plans), physician, nursing supervisors, and the case manager.

3. Starting the week of 12/29/19, the DON will be monitoring and reviewing labs and lab results with the infection control nurse and the MDS nurses weekly for the next 3 months to ensure care plans are updated and accurate.

4. Residents on isolation will be discussed daily in the daily update/admission meeting, and weekly in the resident level of Care meeting. The DON will report findings of all reviews to the QAPI program quarterly.

Completion Date: 12/31/19

ATTACHMENT D

F 658

Services Provided Meet Professional Standards

1. On 12/11/19, a HgbA1c was drawn on resident #4 per a physician order. On 12/11/19, restraint reduction assessments were added to Resident #82's orders for Nursing.

2. On 12/11/19, chart reviews were initiated on all residents in-house to identify any orders that had not been completed. Chart reviews on all in-house residents will be completed by 12/31/19. Any orders found not completed will be conveyed to the physician and responsible staff will be subject to disciplinary action.

3. On 12/23/19, in-services were initiated on the topic of following physician orders, how to follow/enter orders, and adding a restraint reduction assessment to each resident who has restraint orders.

4. Beginning on 12/30/19, nursing supervisors will perform random chart reviews weekly for any orders found to have been entered into the system incorrectly, or to not have been followed. They will report any issues to the physician and the DON for corrective action at that time. Results of chart checks will be discussed in the quarterly QAPI meeting.

Completion Date: 01/25/20

ATTACHMENT E

F 695

Respiratory/Tracheostomy Care and Suctioning

1. On 12/21/19, the inline/sterile suctioning policy and procedure was updated adding the statement "discard tubing if not connected to cap".

2. All residents in the respiratory unit with tracheostomy site will have a suction canister with tubing at bedside therefore all residents on unit have the potential to be affected. The respiratory therapist will follow the policy of discarding tubing that is found not to be connected to the equipment.

3. The monthly in service for January 2020 is to review the policy on suction and the storing of the tubing and the canister when not in use. All respiratory therapists will review and sign off on the policy by 1/25/20.

4. When tubing is set to be changed on Tuesday and Friday, random spot checks will be held the first 3 months of 2020 to insure the policy is being followed and will be reported in the Quarterly QAPI meetings for the first quarter of the year.

Completion Date: 01/25/20

ATTACHMENT F

F 758

Free from Unnecessary Psychotropic Meds/PRN Use

1. Staff who did not enter 2-week stop date on PRN psychotropic orders received disciplinary actions. Medication for Resident #56 was discontinued per NP order. Resident #33 has documentation from the Physician on the continued need for PRN medication.

2. The ADON audited resident charts for PRN anti-psychotropic medications with no stop dates or documentation for continued need of medication. The audit will be completed by 1/13/20. The physician will be notified of any discrepancies.

3. The pharmacy consultant has been instructed to audit each resident on PRN anti-psychotropic medications. Any concerns will be communicated in the monthly physician recommendations sheets as a double check to ensure that stop dates or documentation for continued administration is in place. The GeriPsych Nurse has been instructed to ensure that documentation is in place for those residents on PRN anti-psychotropic medications justifying their use.

4. The pharmacy consultant will be performing monthly audits, and MDS nurses will be randomly auditing orders weekly for the next 3 months starting 12/30/19, for PRN anti-psychotropic medications with no stop dates. Any orders found to be out of compliance will be corrected and results of audits will be reported in the quarterly QAPI meeting.

Completion Date: 01/13/20

ATTACHMENT G

F 880

Infection Prevention and Control

1. After being informed by the surveyor on 12/11/19, that the staff failed to post correct signage for droplet isolation for Resident #20 and RN #1 failed to wear proper personal protective equipment before entering the room of Resident #38. The infection control nurse immediately placed the correct sign on the door of Resident #20.

   The ADON conducted a one-on-one in-service with RN # 1 concerning wearing proper personal protective equipment before entering resident isolation rooms on 12/12/19.
   The DON conducted a disciplinary action with the infection control nurse concerning posting correct signage for isolation on 12/30/19.

   Beginning 12/16/19, and ending 1/15/20, the DON and/or ADON conducted/will conduct a mandatory in-service with all nursing staff (RNs, LPNs, CNAs,) concerning isolation signage and wearing proper personal protective equipment. This mandatory in-service will be conducted either in person in a classroom setting, 1:1 in person or by telephone. Any staff who fails to comply with the points of the in-services will be further educated and/or progressively disciplined to ensure compliance.

2. All residents could be affected by this unacceptable practice. On 12/12/19, the infection control nurse checked all the other isolation rooms for correct isolation signage. None were found.

3. The ADON and/or infection control nurse will observe at least weekly for four weeks beginning 12/16/19, and then reduce to monthly for proper signage and employees wearing proper PPE equipment when entering isolation rooms. Monthly observations will be continued and conducted by ADON and/or infection control nurse until 100% compliance has been achieved per facility policy.

   Beginning 1/2/20, the ADON and infection control nurse will observe all staff entering isolation rooms to ensure compliance with policy and that best practices are followed. This will end when the QAPI committee deems compliance has been achieved.

4. Beginning 1/1/20, the DON will report quarterly to the QAPI Committee concerning the observation of donning personal protective equipment prior to entering isolation rooms and proper isolation signage, however, any concerns identified will be addressed as discovered, including any needed education and/or progressive discipline.

Completion Date: 01/25/20

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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E 000	Initial Comments An emergency preparedness survey was completed 12/9/19 to 12/11/19 at West Meade Place. No deficiencies were cited under FED-E-1.00.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ADMINISTRATOR | (X6) DATE: 12-30-19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.